Masters in Professional Studies by Psychotherapy

Awarded by Middlesex University

A joint programme between the
School of Science and Technology, Middlesex University
and Metanoia Institute.

An inquiry into the relevance of the current model of continuing professional development to the work of psychotherapy.

David Fender

Summary

Name:

David Fender

Post Currently Held:

Psychotherapist in private practice

Title of Final Programme:

Masters in Professional Studies by Psychotherapy

Title of Final Project:

An inquiry into the relevance of the current model of continuing professional development to the work of psychotherapy.

Composition of programme of study

Module	Module Title	Credit	Completed/ To be completed		Passed?
			Semester	Year	
DPY 4421	Review (RPPL)	20	Second	2011	Yes
DPY 4442	Research Challenges	40	Second	2011	Yes
DPS 4443	Practice Project (PEP)	40	N/A	N/A	N/A
RAL at L4	Recognition and Accreditation of Learning	40	Second	2011	Yes
DPY 4444	Programme Planning	40	Third	2012	Yes
RAL at L5	Major project capability	120/180	N/A	N/A	N/A
DPY 5547	Professional Knowledge	40		2013	*
DPY 4560	Final Project	60		2015	

* I have attended six professional knowledge seminars. I have written the Professional Knowledge report but have not submitted it for assessment.

Abstract

Originally conceived as a doctoral research project into continuing professional development (CPD) for psychotherapists this report touches only on a few of the key themes identified.

A qualitative enquiry with five therapists was supplemented with a questionnaire completed by forty one therapists and a review of the CPD requirements of the leading professional bodies.

This research indicates that therapists are dedicated to self-development but the nature of their development is more emergent than planned; and life experiences, learning from clients and acceptance in the professional community are valued above more traditional concepts of CPD.

Contents

Introduction to the researcher

My name is David Fender, I am 61 years old, and work as an independent psychotherapist and organisational consultant.

I was born in North London and was bright enough to get into a Grammar School and still remember what I learnt of literature, maths, natural sciences and music. I was lucky enough to receive a liberal education the aim of which was to produce – '*people who go on learning after their formal education has ceased; who think, and question, and know how to find answers when they need to'*. (Grayling, 2001, p. 158). This liberal education also taught me to read – a passion that – *'grants access to the great country where one flies as an eagle over the history, comedy, tragedy and variety of human experience, at every point garnering much, if the reading is attentive, from the abundance on offer'*. (Grayling, 2001, p. 179) .

Bright but not focused at school I was a serial *'must try harder'*: but try harder to what end I never knew. Leaving school without a clear career path I drifted headlong into the hotel industry in which I moved steadily from trainee to assistant manager, director of food and beverage, general manager and finally director of operations for 18 Marriott hotels. Following a company take over I moved into the world of catering and became managing director of a series of hospitality companies.

Although capable at school it was only when I found a subject that fascinated me that I began to study because I wanted to. At the start of my career I read books on catering and cooking, to the point where I was able to take my City and Guilds exams, without having been to college, and then enrolled on a day-release course for the professional hotel management association exams. When I moved to a hotel accounting job I took as many of the relevant correspondence courses as possible. Next my interest in wine led me to take the '*Diploma in Wines and Spirits'*. The introduction of computers in the 1980s saw me start a degree in *'Business Economics and Computer Science'* and finally a fulltime *'Master's degree in Business Administration'* (MBA) at Cranfield Business School.

My interest in the subjects of my career was not driven out of ambition but from a simple desire to know more about a subject that fascinated me and my aspiration to know as much as I could about all aspects of relevant practice and theory. I enjoyed the study and generally found it easy. I felt more competent and valued because of my knowledge.

Many times I have asked myself why knowing and being the best I can are important to me. It feels like a very deeply held belief because I take it to be self-evidently true and yet I know that there are people, perhaps many people, who do not believe this to be important. I will never know with certainty where this desire comes from but, if I have to guess, it is from the example my father set me. He always encouraged my interests and provided a constant supply of *'Look and Learn'*, *'Nature'*, and *'Knowledge'* periodicals plus *'Time Life'* books. From him I learnt that learning was fun and important, and that to be successful knowledge and attitude were fundamental.

At the turn of the century I left corporate life to become an organisation consultant and eventually a Gestalt psychotherapist. Again, driven to have a sound base of knowledge, I enrolled on a *'Masters in Organisational Consulting'* (AMOC) at Ashridge Business School. My tutor pointed out that I was lacking a degree of psychologically mindedness and suggested I gain some insight into psychotherapy – thus began my exploration of Gestalt Psychotherapy.

So, whilst still completing my AMOC degree, I *'bit the bullet'* and enrolled on the '*Professional Diploma in Gestalt Counselling'* at the London Gestalt Centre which involved seeing clients, personal therapy, supervision, process groups and, of course, academic work.

The Diploma did not quench my thirst for knowledge and I moved to Metanoia to undertake a '*Master's Degree in Gestalt psychotherapy'* plus undertaking various day, weekend and residential courses and conferences.

I would have said that I do not have a background in research but that is not really true. In any half decent restaurant or hotel the employees are going to ask '*did you enjoy your meal? or 'did you have a good night's sleep'* and so, when I started working in that field I too became an action researcher – systematically gathering data in order to create new knowledge and in the process change things for the better; *when are we most busy, what is the best-selling dish, what wines are selling, when do guests complain, what are our competitors doing…* every day I was part of a research team gathering the data to make things work better.

Such informal data collection was supplemented with increasingly sophisticated quantitative methods; most hotel companies now measure guest and employee satisfaction using online randomised surveys. I became a champion of informed decision making. My MBA studies at Cranfield School of Management gave me the opportunity to learnt a lot about market research and quantitative methods.

The first time that I undertook what I would call *'proper academic research'* was for my AMOC degree where I used an unstructured combination of action research, interviews and focus groups to examine the phenomena of generative conversations – those conversations, in an organisational context, that produce new knowledge, ideas or understanding.

Today I would recognise myself as a researcher; I am informally researching the world of my psychotherapy clients with an open mind and an open heart. I am interested to know what is actually happening, as far as is possible uncluttered with presuppositions and theories that are remote from the here-and-now situation. I know I bring a life time of prejudices and assumptions and I battle to keep them from clouding my sight. I know – '*we don't see things as they are, we see them as we are.'* (Anaïs Nin) but I attempt to see the situation from the perspective of the other.

I like to think I am *'bilingual'* – I can read and write in both words and numbers and hence I value the unique perspectives that both qualitative and quantitative research can bring to the search for understanding. For some, increasing age brings a more rigid world view; for me it has brought a growing understanding and acceptance of complexity. I want data, knowledge, theories and opinions but I no longer expect certainty. In my research I do not expect to find answers or solutions, I do not expect to produce new theories or models, but I do hope to add to the debate, add to the total sum of knowledge. That in itself would be a fine thing to accomplish.

Why is this research important to me and to the profession of psychotherapy?

In each phase of my professional life I have diligently sought to be the best I could be. I have done this by increasing my skills and knowledge through a wide range of development activities. As a psychotherapist I am aware that my desire to improve my abilities is even stronger than formerly. There is more of 'me' tangled up in this role. The sense of expertise and mastery that I have experienced in other aspects of my life elude me in my consulting room. Being a therapist, for me, means I have to be real in the room. These expectations expose my limitations as a therapist and a human being.

I cannot ethically avoid this situation but, as in other areas of my life, I have looked to increase my knowledge, skills and experience to support me. On reflection I undertake professional development because:

- part of me still believes that the next workshop, the next book or the next personal development group will give me *'the answer'* as to how best to support my clients,
- the subjects fascinate me,
- it gives me a sense of *'I'm doing the best I can'*,
- I feel it proves to the *'world'* that *'I'm doing the best I can',*
- I need specific knowledge or skills for a particular situation,
- I have a professional obligation to undertake supervision and a specific amount of professional development,
- I am a habitual life-long learner.

For all these reasons I am a big consumer of professional development and, generally, colleagues profess to being equally committed to their on-going professional development. This drive for development seems to be ubiquitous: writing in the forward *to 'Core Competencies in Counselling and Psychotherapy: becoming a highly competent and effective therapist'* (Sperry, 2010, p. xvii) Kaslow states that:

> *'After all, we all strive to be the best we can as clinicians…'*

The central role of professional development, in increasing and maintaining therapists' effectiveness, is to a large extent taken for granted. Opportunities aimed at developing our skills, knowledge and qualifications are limited only by the time and money we have available; therapists are bombarded by adverts for courses, new books, journals, conferences, workshops, additional qualifications and supervision. So how do we know if any of these activities will help us be more effective therapists and, if it does, then how can we choose which development will help us fulfil our potential as therapists?

Psychotherapy accrediting organisations, in line with almost all professional bodies, require a certain number of hours of continuing professional development and supervision to be completed each year. The required process of planning, recording, evaluating and auditing professional development has become more onerous. And yet virtually any vaguely related activity can be used to fulfil the professional criteria. There appears to be no research as to what is most useful for a particular individual and how one could most effectively design one's own personal development plan.

If Kaslow's dictum that '*we all strive to be the best we can as clinicians'* is correct, which I think for me it is, then how does professional development contribute to this aim? And fundamentally what would the development look like that would help us become the *'the best we can'*?

In accord with Kaslow's dictum I want to be to be the best clinician I can; I want to be a Super-shrink not a Pseudo-shrink! (Ricks, 1974). Will continuing professional development enable me to achieve this? And, if so, how best should I spend my time and money? If being the best clinician I can be is more about *relating*, than it is about *doing,* then what sort of development will best facilitate the necessary growth of my ability to relate?

Literature review

In reviewing the relevant literature I have had to have a sharp focus as the field of professional development and learning is vast. I have set out to place CPD in the wider field of developing the skills of the psychotherapist but, before looking at what sort of development impacts psychotherapeutic practice, I felt it necessary to try to establish what skills would be most important to a therapist and to do this I needed to understand what makes psychotherapy effective in relieving emotional distress.

Therefore the route I have taken through the literature is first to establish what makes psychotherapy effective, then to review the research regarding what psychotherapists report as impacting their practice. I have taken a diversion into learning styles and models and then considered how CPD is viewed by other professions and our own professional bodies.

What makes psychotherapy effective?

In 1974 D.F. Ricks (1974) described therapists who achieved exceptional results with their clients. Okiishi et al. (2003) in the introduction to their study of the individual effectiveness of 91 therapists, state that little research has been done since Ricks' on the effect of individual therapists but attention has, rather, focused on the effectiveness of the modality of therapy provided. In their study they observed that the best performing therapists achieved a rate of change ten times the average for the population and that the clients of the poorest performing therapists actually got worse. They did not observe a correlation between effectiveness of the therapists and the type of training, amount of training, theoretical orientation or gender of the therapists. They concluded that:-

> *'Investigation of therapist development could also be important to examine. How did these therapists become significantly better or worse than their peers?'*
> (Okiishi, Lambert, Nielsen, & Ogles, 2003, p. 372)

Analysis of 6,146 patient outcomes by 581 therapists also identified the phenomena of therapists that achieved significantly better results (Wampold & Brown, 2005).

The occurrence of so called '*super and pseudo-shrinks'* (Ricks, 1974), although not found by all researchers (Elkin, Falconnier, Martinivich, & Mahoney, 2006), led Miller et al. to ponder:

> *'If being the best is a matter of birth, personal disposition, or chance, the phenomenon would hardly be worth further study. But should their talents prove transferable, the implications for training, certification, and service delivery are nothing short of staggering.'* (Miller, Hubble, & Duncan, 2008, p. 16)

Although there is ample evidence that psychotherapy is effective at relieving psychological suffering it is less clear how this happens particularly as modalities with very different theoretical and philosophical starting points appear to be equally effective. Frank and Frank (1991, p. 40) synthesise the basic elements of all psychotherapeutic approaches and identified the following four common features:

- *'emotionally charged, confiding relationship with a helping person',*
- *'a healing setting'* – designed to communicate particular expertise, thereby raising the hopes of the client; office, dress, certificates etc.
- *'a rational, conceptual scheme, or myth that provides a plausible explanation for the patient's symptoms and prescribes a ritual or procedure for resolving them',*
- *'a ritual or procedure that requires the active participation of both patient and therapist and that is believed by both to be the means to restore the patient's health'*.

This model was later described as the *'contextual model'* by Wampold (2001).

Wampold (2001) compares the contextual model with the medical model '*which presumes that the application of specific techniques to particular mental disorders is responsible for positive outcomes'* (Hansen, 2014, p. 83). The analysis of outcome studies demonstrated that the contextual model was the clear winner with *'specific ingredients accounting for only 1% of the variance in outcomes'*. (Hansen, 2014, p. 83)

Why then has the demonstrably less effective medical model continued to enjoy increasing domination in psychotherapeutic thinking? Hansen argues that the obvious answer is that *'money, power, and prestige are associated with the medical model'.* (2014, p. 87)

What type of development impacts psychotherapeutic practice?

A widely quoted and influential theory of the development of professional expertise has been put forward by K. Anders Ericsson. Whilst Ericsson concedes that the widely held view is that performance is largely determined by innate ability he argues that –

> *'…acquisition of expert performance requires engagement in deliberate practice and that continued deliberate practice is necessary for maintenance of many types of professional performance.'* (Ericsson, 2004, p. S70)

Applying Ericsson's work to the field of psychotherapy Miller et al. (2008) identified that better performance was correlated with working harder; but also with working smarter. This working smarter entailed firstly identifying a base line effectiveness, then engaging in deliberate practice and then receiving and reflecting on feedback to plan future interventions – thus completing a classic action learning cycle.

In their qualitative study of 12 senior psychotherapists, Rønnestad and Skovholt (2001) identified four primary *'learning arenas'* for professional development:

- *'Early life experience.*
- *Cumulative professional experience.*
- *Interaction with professional elders.*
- *Experiences in adult personal life.'*

They concluded that profound experiences in any of these four areas will impact the clinical work of the therapist and that on-going reflection and processing of experiences are necessary for optimal development.

Based on a cross-sectional and longitudinal qualitative study of the development of nearly 5,000 counsellors and therapists, Rønnestad and Skovholt (2005) identified six developmental phases:

1. *Novice*
2. *Apprentice*
3. *Graduate*
4. *Established*
5. *Seasoned*
6. *Senior*

The top three positive influences on current development for phases one to four were:

- *'Experience in therapy with patients'*
- *'Getting personal therapy, analysis or counselling'*
- *'Getting formal supervision or consultation'*

with *'Taking courses and seminars'* only making the top three for the most experienced, and presumably most out of date, therapists. (Orlinsky & Rønnestad, 2005, p. 155)

Rønnestad and Skovholt, (2013) identified ten themes of professional development – see appendix 2 for complete list. A number of these themes are important to an examination of CPD. Theme 2 – '*the modes of therapist/counsellor functioning shifts markedly over time - from internal to external to internal'.* This describes how, prior to training, the *'lay helper'* is guided by common sense and intuition, as they undergo training this shifts to following the external theories and techniques they are learning, but returns to an internal focus of functioning, as they enter the professional phases of development.

Theme 4 – '*professional development is a lifelong process'* – highlights how long it takes before the integration processes are completed and how this integration is facilitated by the '*therapist's perception of themselves as they grow as professionals'.* (2013, p. 150). At each of the first four career stages between 83% and 92% of therapists rated professional development as highly important: this declined to 73% for senior practitioners. (Orlinsky & Rønnestad, 2005, p. 251).

Theme 6 – '*an intense commitment to learn propels the development process'.* The authors were impressed with an *'attitude of reflective awareness and an eagerness to learn and develop'.* Those therapists with 20 or more years of practice also reported '*a sense of growth characterised by experiences of improving, becoming skilful, and feeling a growing sense of enthusiasm about doing therapy*'. (2013, p. 150)

Theme 8 – 'interpersonal sources of influence propel professional development more than "impersonal" sources of influence'. Therapists rated *'interaction with clients as most impactful for their professional development. Furthermore, supervision and personal therapy were rated second and third, and personal life was frequently rated fourth.'* Courses, seminars, books and journals were rated as less important whilst '*Clients as primary teachers'* and '*Personal life impacts professional functioning and development throughout the professional life span'* were seen as important sub-themes.

A study of ten '*master therapists'* (Jennings & Skovholt, 1999) identified a number of common characteristics such as they were *'veracious learners'* and also engaged in activities to increase their ability to be more *'emotionally receptive'* – e.g. undertaking peer groups, personal therapy and supervision to heighten this characteristic.

Professional development and learning models.

How professionals develop competence is the subject of numerous theories. The early theory of learning based on simple behaviourism *'is now widely regarded as overly reductionist, but aspects of it undoubtedly work'* (Cheetham & Chivers, 2001). Cognitive theories focus on what happens between the inputs and outputs of behaviourism – e.g. memory, problem solving, how information is taken in and processed. In this regard the Gestalt psychologists (e.g. Lewin, Kofka, Wertheimer) proposed that learning is most usefully viewed as a whole (a Gestalt) and cannot be broken down without losing the essential nature of the process.

A model of learning analogous to cybernetics (inputs, processing, outputs and feedback) was developed for both organisational and individual learning. The concept of *'single and double-loop learning'* (Argyris & Schön, 1996) where the *'theory-in-use'* is either maintained or needs to be revised, has been particularly influential.

Cheetham and Chivers highlight three influential theories of adult development (Cheetham & Chivers, 2001):

- *Andragogy,*
- *Symbolic interactionism,*
- *Experiential learning.*

Andragogy, principles for teaching adults, is most closely associated with Knowles whose principles include for example:

- *'People become ready to learn something when they experience a need to learn it in order to cope more satisfyingly with real-life tasks or problems.'*
- *'Learners see education as a process of developing increased competence to achieve their full potential in life.'*

(Knowles, 1980, p. 44)

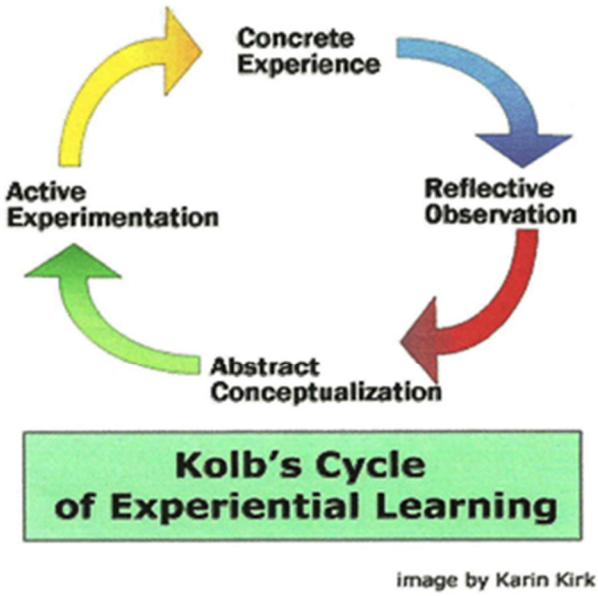
Although, to me, these principles appear self-evident and have been used to shape numerous development programmes, there has been criticism (Jarvis, 1984) that they are not based on sufficient research.

Symbolic Interactionism describes a philosophy emphasising such factors as self-awareness, self-image and self-esteem (Cheetham & Chivers, 2001). Symbolic Interactionism proposes a number of principles, similar to Andragogy, but emphasising the social interactive aspect of adult learning. For example, Brundage and MacKeracher, (1980) postulate that adult learning is facilitated when:-

- *'the learner's representation and interpretation of his own experience are accepted as valid, acknowledged as an essential aspect influencing change, and respected as a potential resource for learning.*
- *teaching activities do not demand finalized, correct answers and closure; express a tolerance for uncertainty, inconsistency, and diversity; and promote both question-asking and -answering, problem-finding and problem-solving.'* (Brundage & Mackeracher, 1980)

The concept that we learn from *'doing'* is referred to as *'Experiential Learning'* and has been the basis for the *'Kolb Learning Cycle'* (below) that shows learning as a process and connects experience with reflection and conceptualization. Experiential learning takes place when a learner undertakes an activity, reflects on it critically, determines what was useful or important to remember, and uses this information to perform another activity." Kolb (1984) defines learning as:

'the process whereby knowledge is created through the transformation of experience'.



Many (more than 70) different theories have been proposed indicating that learners have different preferences in how they learn – i.e. Learning Styles. Although the concept has been much criticised it remains popular and extensively used in organisations. Three of the most widely known models are:

- *Kolb's ELT model which features a simple two-by-two matrix of 'Grasping Experience': either 'concrete experience' or 'abstract conceptualization', and 'Transforming Experience': either 'reflective observation' or 'active experimentation'. According to Kolb's model, the ideal learning process engages all four of these modes in response to situational demands.*

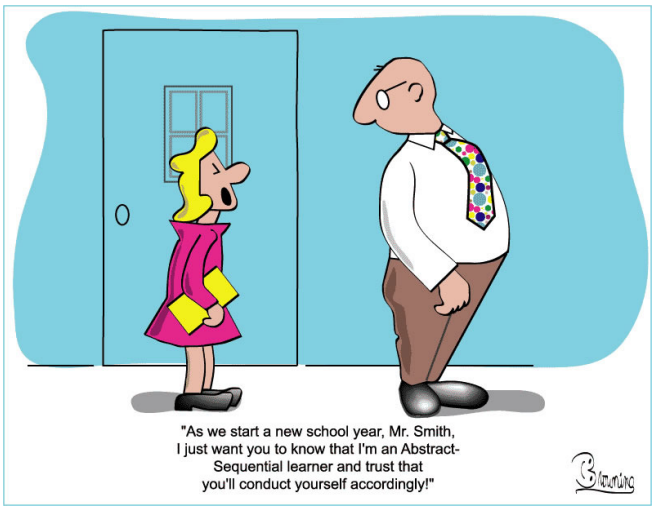
- *Honey and Mumford's model is based on Kolb's experiential model: having an experience, reviewing the experience, concluding from the experience, and planning the next steps. The resulting 'learning styles' reflect the different stages of the cycle and are named Activist, Reflector, Theorist and Pragmatist.*

- *Neil Fleming's VAK/VARK model is based on Neuro-linguistic programming models and divides people into: visual learners; auditory learners; and kinaesthetic or tactile learners.*

In his seminal work, Donald A Schön,'T*he Reflective Practitioner*' (1983) examines the nature of professional knowledge and how it differs from academic knowledge and concludes that much professional knowledge is *'knowing-in-action'* – i.e. actions, recognitions and judgements which we know how to carry out spontaneously but are unaware of having learnt. Such *'knowing-in-action'* can, through *'reflection-in-action'*, be identified and critiqued and new meanings found.

> *'It is this entire process of reflection-in-action which is central to the "art" by which practitioners sometimes deal well with situations of uncertainty, instability, uniqueness, and value conflict'.*

(Schön, 1983, p. 50)



CPD - theory and practice

According to Friedman et al. (2008, p. 1) the following definition of CPD, developed in 1986 by the UK Construction Industry Council, was still the most frequently used by UK professional bodies in 1999.

> *'The systematic maintenance, improvement and broadening of knowledge and skills, and the development of personal qualities necessary for execution of professional and technical duties throughout the individual's working life.'*

Key points in this definition are that CPD:

- is systematic, presumably, in its planning, delivery, monitoring and assessment,
- is for the maintenance of knowledge and skills - keeping up-to-date,
- is for the improvement and broadening of knowledge and skills - developing new skills for the future,
- is also for the *'development of personal qualities necessary for execution of professional and technical duties'*,
- is necessary throughout the individual's working life.

The term CPD is intended to embrace informal and on-the-job learning rather than just formal qualifications and courses. CPD brings together education and practice and presents it in a structured way that gives professional credibility and kudos.

In many professions continuous professional development (CPD) is viewed as very important. In 2008 Professional Associations Research Network (PARN) carried out research to ascertain how professionals, across a variety of professions, felt about CPD: how much they did, what type they did and why they did it. Professionals from health, finance, law, business, environment, engineering, science, education, social, media and culture were represented.

- *69% of respondents stated that their overall attitude towards CPD was 'positive' or 'very positive',*
- *87% rated 'it is my duty as a professional to do it' as 'important' or 'very important',*
- *83% rated 'I do it to improve performance in my current role' as 'important' or 'very important' and 71% 'I do it to develop as a person'*,

- *factors such as 'I do it to further my position with my current employer '(40%) and 'it is explicitly included in my regular appraisal process' (39%) were viewed as less important.*

(Professional Associations Research Network, 2008)

In 2011 PARN published a further report (Williams & Hanson, 2011) examining the move towards compulsory CPD. The report examines the reasons for professional associations to adopt compulsory CPD, and how such schemes are monitored and the sanctions for non-compliance. A key differential, the report identifies, is between '*Input Schemes*' (measuring what CPD you do) and '*Output Schemes'* (measuring what you learn) which are much less common.

According to *'PARN International Benchmarking Survey 2009'* of professional associations 78% reported having a CPD policy, and of those CPD was compulsory in 35%.

The research identified that the strategic objectives for implementing compulsory CPD fell into three broad categories:

- *to improve the image of the profession and the professional body,*
- *to promote good practice and keep the profession up to date,*
- *to meet the standards of a third party.*

Measurement of CPD

Those professional bodies with compulsory CPD need to implement a system of measurement. Designing, developing, implementing and administering a measurement system puts an additional level of expense onto the professional body which, in turn, must result in higher membership fees. Research by PARN (Williams & Hanson, 2011) shows a trend towards professional bodies implementing compulsory CPD policies and thus measurement systems. The introduction of compulsory CPD is often to comply with external legislation or registration requirements.

Measurement of CPD can be based on inputs or outputs. Input measurements are more objective as they count the number of hours of CPD undertaken and are relatively simple and cheap to implement and monitor. They can be made more sophisticated by differentiating between types of CPD and converting hours to points according to a predetermined scale that, for example, gives a credit for each hour spent at an approved course, but only half a credit for each hour spent reading a relevant book. Further differentiation can be between formal and informal learning, accredited or non-accredited programmes, structured or non-structured study, core and optional subjects, and examined and non-examined courses. Some systems are quite specific as to what

activities can be counted as CPD, for others the list is almost open ended. Achievement of the required hours is usually spread over a number of years with minimum hours set for each year.

Some professional bodies have introduced the concept of an *'effectiveness index'* – the professional themselves rates the impact on their practice of the CPD hour. The product of the *'effective index'* and the number of hours becomes the '*claimable hours'* of CPD. Although subjective and easily manipulated this systems does at least introduce an element of output measurement.

Against the advantages of simplicity and low cost the input method has the major disadvantage of not measuring impact, at best it measures that something has been done and assumes that attendance or participation adds value, which may not be the case.

In the study '*Approaches to CDP Measurement'* Friedman and Woodhead state that, at the time of writing (2008), output measurement was a relatively new activity that was not well understood and there was little evidence of a best practice method. In their 2011 research Williams and Hanson (Williams & Hanson, 2011) identified that 81% of the professional bodies surveyed had a formal system of CPD measurement.

Most CPD policies require that a variant of the learning cycle (Kolb, 1984) is used in planning and evaluating CPD. Such policies require that the four interrelated steps of the cycle, each of which is deemed to be independently valuable, should be followed to plan, evaluate and assess the robustness of an individual's personal CPD.

Summary

In summary my brief literature search has highlighted:

- that the individual therapist impacts the outcome of the therapy,
- there are numerous factors contributing to therapists' development,
- the field of adult and professional learning is vast and certain theories have elements that could illuminate the experience of therapists' development,
- professionals, from various spheres including psychotherapists, attribute great importance to continuing professional development.

Continuing professional development policies

For each of the major professional bodies for counselling and psychotherapy I have listed their definition of CPD and their key CPD requirements. As a comparison I have also included the General Dental Council. All definitions and policies have been taken from the relevant organisations' websites.

British Association of Counselling and Psychotherapy

Definition of CPD

> *'Any learning experience that can be used for the systematic maintenance, improvement and broadening of competence, knowledge and skills to ensure that the practitioner has the capacity to practise safely, effectively and legally within their evolving scope of practice. It may include both personal and professional development.'*

Key requirements

- *To keep an up-to-date and accurate record of CPD activities using the template provided by BACP Register.*
- *To record a range of CPD activities relevant to current or future practice.*
- *Show clearly how you have reflected, planned, actioned and evaluated your development needs and indicate how this will have an impact on your practice. (Learning Cycle)*
- *Submit your record upon request.*

United Kingdom Council for Psychotherapy

The UKCP has published a policy document that sets out minimum standards and guidance for the various Institutional Members to produce their own CPD policy statements.

Definition of CPD

> *'the systematic maintenance, improvement and broadening of knowledge, awareness, skills, abilities and the development of personal and professional qualities necessary for the effective practice throughout the practitioner's working life. It will, in the main, be in a manner consistent with the practice of the modality.*
> *The fundamental principle underpinning all CPD activity is the protection of the public*

through the maintenance and improvement of professional standards.'

UKCP CPD principles, requirements and guidelines. 2009

Key requirements

- *A self-designed programme of study and engagement in complementary professional activities (at least 20 hours per year) and 250 hours over a five-year period.*
- *A programme to stimulate, stretch and support you, as well as to keep abreast of relevant developments in the field.*
- *Activities may include a wide variety, for example, research, reading, writing, attendance and presentations at conferences and workshops, serving professional organisations on boards/committees, peer group discussion meetings, participating in an online colloquium, further training in the original or another discipline or other activities that support your practice as a professional.*

Metanoia Institute CPD Policy for graduate psychotherapists 2014

British Psychological Association

Definition of CPD

The Health and Care Professions Council monitors the CPD of members and defines CPD as:

'a range of learning activities through which health professionals maintain and develop throughout their career to ensure that they retain their capacity to practise safely, effectively and legally within their evolving scope of practice.'

Key requirements

- *CPD is both a professional expectation and an individual responsibility, with the understanding that you will take a structured and self-managed approach to further learning through:*
    - *actively engaging in CPD,*
    - *maintaining a record of your CPD,*
    - *applying learning from CPD to your professional practice.*

- *There is a range of formal and informal learning activities that may be used for CPD and it is recommended that you engage in a mix of CPD activities.*

- *Professional development is not purely about inputs (i.e. undertaking CPD activities); it also requires a reflective outcomes-based approach, which focuses on the learning gained from CPD and its application to current or future practice, together with the associated benefits for you, your clients and the services you provide.*

- *As all members who are registered with the Health and Care Professions Council (HCPC) are legally required to comply with their CPD requirements, we will not be undertaking CPD monitoring that might overlap with the HCPC's duties as the independent regulator.*

- *The Society recommends that you set aside dedicated time for CPD. Whilst recognising that it is the learning outcome, rather than just the time spent that is important, the Society is aware that many members have asked for guidance as to the minimum amount of time needed for CPD. Bearing in mind that you will need to undertake varying amounts and different types of CPD at different stages of your career, the minimum amount of time needed for engagement in CPD is likely to be between half and one day per month.*

General Dental Council (UK)

Definition of CPD

> *'Study, training, courses, seminars, reading and other activities which advance your professional development as a dental professional.'*

Key requirements

- *Practitioners are required to carry out at least 250 hours of CPD every five years. At least 75 of these hours need to be 'verifiable' CPD and certain subject areas are recommended.*

- *'General CPD' are activities which benefit continuing professional development but cannot be independently checked (for example, private study) or do not meet all of the criteria for 'Verifiable CPD'.*

- *'Verifiable CPD' are activities for which there is documentary proof of attendance and which had: concise educational aims and objectives, clear anticipated outcomes and*

quality controls. The individual is responsible for deciding whether or not to designate an activity as verifiable CPD.

- *Specific subjects are recommended as part of the 75 hours of verifiable CPD: medical emergencies, disinfection and decontamination, and radiography and radiation protection.*
- *It is also recommend that practitioners keep up to date by doing CPD in: legal and ethical issues, complaints handling and oral cancer early detection.*
- *CPD logs can be downloaded and failure to meet the requirements can result in practitioners being removed from the register.*

Summary

- All of the major psychotherapy professional bodies have a similar CPD policy which requires:
    - a planned approach to CPD using a learning cycle structure,
    - a minimum number of hours,
    - formal record keeping in an increasingly prescribed manner.
- A comparison with the CPD policy of other professions suggests that psychotherapy professional bodies have adopted CPD *'best practice'* from other professional bodies.
- As a key requirement is '*to keep abreast of relevant developments in the field*' I was surprised that a similar number of hours of CPD are required for both dentists (high levels of developments in the field) and psychotherapists (low level of developments in the field).

Research methodology

In deciding upon a methodology I had three areas to consider:

- how do I perceive the world and what, for me, constitutes knowledge,
- what actually interests me about this subject and, therefore, what do I want to discover,
- who do I want to influence and, therefore, what type of data will they need.

I realised that these may be in conflict and it might not be possible to balance all of these factors.

How do I perceive the world and what constitutes knowledge

In approaching my research I have maintained a '*scientific attitude'* as defined by Colin Robson - *'by this I mean that the research is carried out systematically, sceptically and ethically'* (Robson, 2011). By *'systematically'* he means that the research is planned and the nature of the process and observations is made explicit. The term *'sceptically'* defines the need to accept that initial ideas may not be confirmed and dissenting and alternative views must be considered. For the research to be *'ethical'* the interest and concerns of participants and interested parties must be considered in the design and implementation.

Although I wish to adopt the *'scientific attitude'* this does not imply that I taking a positivist stance similar to that taken in chemistry or biology *'who operate on an assumption that there is a real objective world that is 'out there' and which is knowable through the application of appropriate methods of inquiry'* (McLeod, 2001, p. 44). Rather I will take a *'postpositive'* view in which I believe that, for example:

- evidence in research is always imperfect and fallible,
- we should be guided by the best evidence we have at the time,
- methods and conclusions should be examined to reduce possible bias and establish reliability and validity,
- research seeks to develop statements which can help explain situations or describe causal relationships.

Based on (Robson, 2011, p. 22)

Goss and Mearns (1997) argue that the difference in epistemological position between quantitative and qualitative research, (ie reductionist-positivist and phenomenological-naturalistic (Goss & Mearns, 1997)), does not mean that we have to choose one or the other; they list various moves '*towards a truce in the paradigm war',* and how a more pragmatic approach, using the most appropriate method depending on the question (open or closed for example) or the stage of research, can yield more valuable results. They do not dismiss the importance of the underlying epistemological differences but rather conclude that *'we have not yet developed a sufficiently rugged epistemology capable of containing the full range of our different ways of understanding'* (Goss & Mearns, 1997).

The debate between advocates of quantitative and qualitative research appeared to be in two irreconcilable camps between which I had to choose. I wanted to have the best of both – but this did not seem possible. Goss and Mearns article allowed me to accept the difference in epistemological positions whilst taking the best each approach could offer.

What actually interests me about this subject and, therefore, what do I want to discover?

As a psychotherapist in private practice I, and colleagues, are not privy to the structures and support evident in organisations, whilst we have an obligation to undertake professional development; a burden placed upon us by our professional bodies. Psychotherapy is relatively poorly paid and yet there is a booming market for CPD – books, courses, video, supervision etc. For the self-employed the cost of CPD is twofold: the cost of the learning, plus the loss of earnings for the absent time. Financially it makes no sense to undertake any more CPD than is necessary to maintain good practice or to develop new client segments and yet it seemed that many therapists, including me, are big, perhaps compulsive, consumers of CPD.

I wanted to know, in a structured way, what my experience of CPD is and what is it like for some of my colleagues. And then I wanted to know if others have similar experiences.

I did not have a theory about CPD that I wished to validate – I wanted to formulate such a theory from the themes expressed in the qualitative research and then see if that theory was validated by a larger population.

My research question:

Is the current model of continuing professional development of relevance to the work of psychotherapy?

In order to explore the experience of professional development for psychotherapists I chose a phenomenological and hermeneutic approach.

Phenomenology and Hermeneutics

All research must start with a detailed description of the subject under scrutiny. For quantitative research we can make measurements and gather facts and figures. For qualitative research we will require opinions, feelings, beliefs, perceptions and emotions. The value of the subsequent analysed and interpreted data will depend on its richness and its accuracy in representing the participant's experience and views. McLeod (2001, p. 21) makes the point that if one were only to get one word answers to questions (eg - fine!) then there would be very little to analyse. *'The aim of phenomenology is to produce an exhaustive description of the phenomena of everyday experience, thus arriving at an understanding of the essential structure of the thing itself'* (McLeod, 2001, p. 25) – this is the exact starting point I need if I am to reach a meaningful understanding of the role CPD plays for practicing therapists.

Such *'raw data'* is of great interest but its value is enhanced if it is subjected to hermeneutic interpretation. The data needs to be understood in a context; I do not share the same context as the participant and have to interpret the data in my context – shaped by my reading on the subject, by my other participants, by regulation and public opinion. My interpretation is not objective as I am doing so as a member of a community with traditions of beliefs and values. Thus the *'interpretation goes beyond the immediately given and enriches the understanding by bringing forth new differentiations and interpretations in the text, extending its meaning'* (Kvale, 1996).

A phenomenological attitude provides rich, detailed data as free from preconceptions as is possible. I require this because I want to know *'what is it like'*. A hermeneutic analysis will allow me to conceptualise the experiences within a wider perspective. Like many great partnerships – it takes two to tango!

Whom do I want to influence and, therefore, what data will be most impactful

In the chapter entitled '*Making an Impact'* Simon du Plock argues that *'research is not a private activity – it has to get out into the world if it is to count for anything'* (du Plock, 2014, p. 174). Although my primary motivation to complete this research was my own curiosity into how other therapists continue to develop themselves, I am also concerned that a vast amount of time and money is spent each year by therapists on professional development, and that professional bodies are imposing an increasing level of control over the choice and quantity of development

undertaken. Therefore I am keen that my research will influence how individual therapists think about their professional development, how organisations will plan professional development for their staff, and the regulations that professional bodies will impose on their members regarding their professional development.

Making my choice of methodology

To capture participants' lived experience of professional development and to use the resulting themes and conclusion to influence professional bodies and therapy providers I kept the focus on it being one research project – with just one research question *'which to be answered properly needs both quantitative and qualitative data collection'* (Robson, 2011, p. 169). Therefore I decided to collect and analyse qualitative data then to triangulate the themes produced by a quantitative questionnaire based survey.

I chose to use Interpretative Phenomenological Analysis (IPA) because, I believe, the following features make it suitable for this research:

- *case-based emphasis,*
- *focus on nuanced, lived experience of participants,*
- *use of sequential set of interpretive 'readings' of the data,*
- *no requirement to construct a formal model from the data.*

(McLeod, 2001, p. 147)

The core of my research is Interpretative Phenomenological Analysis of interviews with five psychotherapists as to their experience of continuing professional development. The key findings from this qualitative research were then used to structure a quantitative survey. This 'multi-strategy' approach was adopted in order to achieve greater validity. Among the many benefits of this approach the most salient for this research are:-

- *'Triangulation. Corroboration between quantitative and qualitative data enhances the validity of findings.*
- *Completeness. Combining research approaches produces a more complete and comprehensive picture of the topic of the research.'*

(Robson, 2011, p. 167)

Method

Qualitative research

By the use of a purposeful sampling strategy I recruited five participants who were considered to be exemplars of '*professional-developers'*. I asked *'well informed'* colleagues whom they considered to be suitable participants and then approached these individuals. As the research is essentially idiographic I recruited participants one-by-one, therefore avoiding the need to reject anyone due to oversubscription.

During the recruitment phase potential participants were informed of the nature and objective of the study and that:

- their data would be anonymised,
- their data would be stored electronically until the research had been completed and then destroyed,
- the data would be processed and published,
- they could withdraw from the study at any time, up until publication, without any requirement to provide an explanation.

There was no reward or coercion to take part; although I did expect the participants to gain some new understanding of their professional development needs and processes by participating.

Once informed consent to proceed had been obtained the first of two semi-structured interviews took place.

- The first interview focused on the participants' understanding and experience of continuing professional development. At this point the participants were encouraged to keep a *'development journal'* for the remainder of the research period.
- The second interview took place after approximately six months and focused on their current experience of development activities and the perceived impact on their clinical practice.

A list of possible questions was used as a guide but the interview was more emergent than structured, lasted between 60 and 90 minutes, were recorded and later transcribed and finally checked for accuracy before commencing the analysis.

IPA was used to analyse the data generated from the semi-structured interviews. IPA is a variant of grounded theory in which the data are analysed in terms of emerging themes and categories – *'there is no attempt to test a predetermined hypothesis of the researcher, rather the aim is to explore, flexibly and in detail, an area of concern'* (Smith & Osborn, 2008, p. 55). This method favours examining fewer participants in greater depth rather than broader shallower analysis.

The following steps were utilised:

- *'reading and re-reading of the data to enter the experiential world of the participant,*
- *initial noting of the data to identify anything of interest or significance,*
- *developing emerging themes,*
- *searching for connections across emerging themes.'*

(McLeod, 2001, p. 148)

Quantitative research

The content of the *'triangulation'* questionnaire was concluded once the initial findings of the IPA study were produced. The questionnaire was written using '*Survey Monkey'* (an internet survey tool) and was tested by colleagues to ensure it *'worked'* and provided the type of data required. Utilising lists of therapists I knew I sent out personalised explanations and requests for respondents to both, complete the questionnaire, and to forward it to suitably qualified colleagues.

The questionnaire explores general attitudes and involvement with CPD; and sought to ascertain if the themes that emerged from the IPA were valid across this wider population. Initially intended to be part of a doctoral project the questionnaire covered a larger number of themes than are reported in this document.

It was not intended that the results would have a high statistical validity but rather they would be seen as supportive, or not, of the themes identified in the IPA study.

Ethical considerations

The original design of this research was given ethical approval by Metanoia's ethics committee as part of my original Doctoral Learning Agreement. All participants were given comprehensive details of the research, including the intention to publish the result, and provided their explicit informed consent to participate. All names and other identifying information have been removed from the data to maintain participants' confidentiality.

Limitations

There are a number of limitations to the quantitative part of this study. The small sample size, and the fact that the sample was non-randomised, limits any generalisations with a high statistical validity being drawn.

The self-selecting nature would I imagine be biased towards those therapists who were positive about self and professional development. Also as the questionnaire was circulated firstly within my network there is a great over representation of Gestalt therapists in the sample. A further limitation is the vague nature of the term CPD which makes comparisons of hours of CPD undertaken problematic.

Whilst having low statistical validity for the total population of psychotherapists I believe that the results do support the key themes illustrated in the qualitative study.

Research findings

The five participants are all female, UK qualified psychotherapists with a number of years post-qualification experience. They could be described as being in either the '*novice professional phase*' or the *'experienced professional phase*' of development (Rønnestad & Skovholt, 2013). All practiced within the humanistic tradition; four being Gestalt trained and one Person Centred.

Of the 41 respondents to the quantitative research 75% were female with 67% having more than ten years post qualification experience. 74% were in the age range of 41 to 60 and a similar percentage was from a humanistic orientation. 87% had at least some private therapy work.

1/ Commitment to development

I undertook this research after reflecting on my own high level of commitment to personal and professional development. I attend supervision every two weeks and am part of two peer groups, undertake on average ten days of workshops per annum, for six years I attended a residential in California and I read theory books, novels, articles, blogs and newsletters about therapy, and favour films and TV series that feature therapists! I wondered if I was unusual in the level of development I undertook.

Albeit that the qualitative participants were selected because they were active self-developers the level of interest and commitment they exhibited was high. For example Vivian described her attitude to development as:

> *'it's something of wanting to be better, wanting to know more, wanting to widen my field and my views, and the more I get… the more I learn, the more I realise what I don't know and I want to know more, and get interested and curious into things, so it's like expansion for me…'*

The *'wanting'* that she expressed felt like a deep desire beyond any economic or professional justification or requirement. She said that *'I need to develop and learn all the time and grow into it (being a therapist)'*. She went on to describe how her need to develop had impacted her life – *'I'd never go on holiday because I'd spend all my money and all my time going abroad (for development)'.* She described her quest for development as – *'bordering on the obsessional'.*

'I think there's something … there's so much you could learn and study in the world of psychotherapy, all those theories and these sort of things. I'm a psychotherapist, I ought to know the history, I ought to know what those people said and did, and I don't.'

All participants described a wide range of interests, activities and formal development that far exceeded the professional requirements – most did not bother to count up their hours accurately knowing that they far exceeded the requirement and would therefore only list the most obvious CPD. Shelly explained how she was *'an avid reader, so I read everything, so I'm always looking at what's around, I'll scan umm … adverts and flyers and e-mails and whatever (for developmental opportunities).'* She described how, in addition to her reading, she was a committee member organising a conference and in recent months had attended four multi-day conferences, organised a one day conference, attended a seminar day, plus supervision, peer supervision and two peer groups.

'*The familiar thing for me is to get stuck, to get paralysed, because it's about how do I choose what to say no to. How do I choose what … to close the door to all those possible paths and opportunities and not go there, I find that really difficult.'*

Angie thought - *'you can't be a psychotherapist without being interested in personal development; at least I would find that rather bizarre'.*

All participants reported a passion to learn and improve, plus a massive curiosity; the only reasons they didn't do more professional development were a lack of time and money. Angie described how she was *'very jealous, one of my peers is going to see Elena Greenbergh!'* Whilst Patty stated that *'I'm eight out of ten for development'* and that *'I would never want to say - this is it, I don't need to learn anything else'.*

Quantitative input

77% of participants reported that they found it *'easy to achieve'*, or '*always over achieve'*, the professional obligation for CPD (50 hours). 44% undertaking more than 75 hours per annum but only 21% thought that amount of CPD was necessary, and 5% thought that more than 75 hours should be mandatory.

One respondent noted that he/she had only listed training events, peer presentations and supervision – whilst many other activities could be counted as CPD. Three respondents wanted a clearer definition of what counted as CPD. Others thought that the mandatory requirement should vary with experience. And one commented that – *'the downside of CPD is that it is so easy to do – but not so easy to integrate into your work'*.

Summary

It appears that I am not alone in wanting to learn and develop myself, and in wanting to know as much as possible about all aspects of my profession. Participants were selected on the basis that they were positive about CPD so it is not surprising that they all confirmed undertaking extensive development activities; many of which came at a high financial cost and negatively impacted other aspects of their life.

This commitment, over and above any formal requirement or objective professional need, was echoed in the quantitative research.

2/ Personal development as professional development

When asked about the activities that developed them as therapists it was notable that most of the responses focused on personal development and how that very directly impacted their ability to be with clients in a therapeutic way.

Vivian described how, for her, development was about finding who she was; it was about developing her *'being'* more than her *'doing'*. Something one of her teachers had told her had really resonated:

> *'no one needs you to be perfect honey, we just want you to be you'*

Hilda wondered whether she could identify a difference between professional and personal development or, does something that develops her personally also develop her as a psychotherapist? She concluded that, as a relational therapist, the *'therapy is me'* and therefore, although *'my personal and professional development are different there is a big overlap'*.

She described how *'birth, death and serious illness'* had all contributed to her personal development - how, particularly, the birth of her child had given her a new understanding of what it meant to be stressed and exhausted. Whilst the *'complexity and uncertainty'*, of her managerial role *'had encouraged her to respond more spontaneously to clients'.*

> *'… I have a completely different understanding of when … being a Mum, when people talk about being tired, I had no idea what that meant, I thought I knew what it meant to be tired, but suddenly something completely new opens up and umm the limit of your capacities and how, in particular, life circumstances you are able to really cross that and you have different priorities of what matters in life.'*

Hilda described how she was involved in a number of projects outside of the world of therapy and how this involvement in the world allowed her to remain grounded with her clients and gave her the opportunity to interact with people with a very different world view to herself.

For Shelly it was the opportunity to be in nature that enabled her to maintain a wider world-view, to remain grounded; to slow down, breathe and connect to other people and the natural world. She did this by working on her allotment – getting her hands dirty, getting physically tired and growing food. She also described how a mindfulness course had enabled her to manage stress in her life:

> *'it doesn't take it away, it's still there, but it's somehow I can breathe, because it's just stopping and just hesitating and breathing, so my … it changed my … it was like inhabiting a different body, I move slower, I'm calmer and more grounded.'*

Angie described her family, personal journey, charity work, advocacy for minorities and how she continued to step outside of her comfort-zone by delivering presentation and training. She explained how she had '*got bolder about standing up and being counted, in the world, so that's probably impacted on me as a therapist, that I not afraid to say it how it is'*. When asked if these experiences had impacted her work she responded that *'they don't directly but I think it's all part of that human kind of expansion of our knowledge'.*

Patty described her struggle with her feeling of inferiority and with personal acceptance. *'Becoming aware that I'm as equal as others because of who I am, as a person, as a human being, regardless of my achievements'* and discovering that *'achievements or lack of achievements don't define me as a human being'*, had given her the confidence to acknowledge *'to know I am good enough'* as a therapist.

Rather than specific CPD she described how supervision, being a supervisor, personal therapy, being with clients, delivering training and managing a counselling service had been most developmental for her therapeutic work.

Shelly summed up her thoughts

> *'I guess what I'm saying is, I don't really see them as neat categories, like if I'm going on a... to a seminar series, to a conference, to a singing workshop, to a concert, to a theatre, they're all part of my life. So is life development? Yes Yes every moment!*

A strong subset within *'Life is CPD'* was '*Growing as a professional is CPD'*. How a feeling of being accepted by peers as a competent professional was a transformative experience. Vivian

described how she knew she was developing because she felt accepted in the therapeutic community and was recognised as a peer by therapists who had been her trainers and mentors.

Shelly described similar experiences: how by being active in various professional bodies she had become *'someone'* in the therapy world and this had encouraged her to rise to others' expectations. She had struggled to *'own her competence'* but this had started to change when she was asked to be on a professional committee.

> *'I think it has an impact on how I work as a therapist, because if I'm feeling more sense of my own ability and, in a sense, more confidence… I'm not just going along as a participant or receiver of all these things … I'm actually part of creating it, then, yes, that will come in to how I am as a therapist, because that … yes, that does change who I am, yes, it expands my sense of myself.'*

As a member of the committee she was a key player in organising a conference and stated that:

> *'I was able to take back my sense of competency from the conference into work, and challenge and stand up for myself and fight for myself and actually I've had some good outcomes - which is very significant.'*

Quantitative input

When asked to rate which activities they most valued for their development 75% of respondents rated both *'life experiences' and 'learning from clients'* as very valuable. A similar percentage (73%) rated *'supervision'* as very valuable. Whilst '*multi-day workshops'* were rated by 70% of respondents as very valuable other CPD options were rated very valuable by a much lower percentage: *'reading'* 50%, '*one day workshops'* 42% and *'peer groups'* 38%.

Summary

Although the participants were all committed to high levels of CPD when asked, what develops you as a therapist, most of the responses were about life events; births, deaths, working in groups, being treated as a colleague. When asked what specific formal CPD has impacted your practice most struggled to identify particular instances, even though they had had notice that they would be asked this question.

For the questionnaire respondents the high value placed on *'life experiences'* and *'learning from clients'* supports the importance of these activities over more formal CPD. The connection between CPD and changes to clinical practice were more mixed, but only 32% identified many

direct connections, a similar percentage (32.5%) to those who could only think of a few or less such connections.

3/ CPD is emergent not planned

When planning her CPD, Hilda didn't follow a structured approach but felt that it was more emergent, it *'comes out of the sort of clients I am seeing. I think - this is new, what do I do about it'*. She identified areas where she felt her underlying values precluded her from working with a client group and that no amount of CPD would change that (e.g. working with fundamentalist religious beliefs) and areas where she had no interest in developing expertise - *'accepting I can't be everything for everyone'.*

When asked if she planned her CPD Hilda replied that:

> *'I do a lot of CPD and it's because I'm interested in things umm … I never do it to comply with certain standards. I actually think the standards of BACP are fairly low in terms of CPD boxes you have to tick… but that's never on my mind. '*

Vivian laughed at my enquiry about her plan for CPD – she explained:

> *'that's why I get stuck. When I think like that, that is when it becomes a must and you have to … I start to think I ought to be better at this and that. I haven't studied enough of that… and I get overwhelmed as criticising myself, not knowing enough'.*

She felt confined and stifled by the thought of having to make a plan.

She explained that she needed to find her unique pathway of theoretical, relational and personal learning and that when she starts thinking she should be planning her development it gets very difficult for her. It's the organic growth that works well for her.

> *'If I'm feeling inspired by the work of someone, and to work with someone, then that is where I can … can then be for some time, until that will lead me to find someone else, or something else, so … more than thinking that I should be training, I should be doing.'*

Shelly, when asked how she chooses CPD said:

> *'The first thing is if something grabs me, it's a … an embodied response, I feel my interest aroused by something - in terms of who's running it, I'll look for people that … if I've read*

something by somebody and I've really enjoyed their … felt touched, moved, by their writing'

Her attitude could be described as - I follow my interests and passions and call it CPD!

'CPD just seems to be like a bit of jargon so that we can tick a box or something. I think what helps me in my development as a professional, I was going to say I don't see it as any different as what … how I develop as a human, but I guess that's not totally true.'

She described how -

'Sometimes I feel like a bee, going to lots of different flowers, picking pollen and then bringing them back and making nice honey. The honey's more tasty actually if you go to … it's quite nice … you know the … mass produced honey, they can put like sugar food for the bees to feed off, but honey that's been collected … made by bees who forage in all different beautiful wild flowers, has some more uniqueness and richness'.

Angie said her CPD was very much on an ad hoc basis and although *'I've got goals, but history has taught me that God always laughs at them'.*

After qualifying Patty had taken a number of different placements with a range of CPD opportunities which she had benefited from. She had in essence allowed the placement to plan her CPD for her but, having finished the placements, was now considering how she could take control of her CPD. She explained that she was '*interested in people's experiences – learning about specific problems even if they are not relevant to my clients'*. When I asked her again, six months later, about her plan she said *'I have no plan for CPD – just vague ideas – I suppose (the plan is) to keep consolidating'*.

Quantitative input

Only 5% of participants indicated that their CPD was totally planned with a further 25% opting for mostly planned. 70% stated that their CPD was either mostly spontaneous or only partly planned.

Only 20% most times or always '*prepared a personal development plan'*, whilst 57% never or rarely do this. CPD was at least sometimes '*discussed in supervision'* by 72% of participants. 60% rarely or never *'keep a reflective journal'*. The most common activity was '*analysing current client issues'* with 82% at least sometimes doing this. Significantly only 3% always '*prepared a personal development plan'*, 15% always *'analysed current client issues'* and 6% always discussed CPD *'in supervision'*.

It could be assumed that for therapists following a planned approach to CPD the three most important factors, of those highlighted, would be: '*to fill gaps in my training', 'to feel more confident/less anxious'* and *'current client issues'.* Whilst the choice of *'follow my passions'* and *'I'm interested in the subject'* suggest a more spontaneous approach. The *'learn skills to support my clients'* could be considered a catch-all motivation.

Whilst 67% rated *'learning interesting stuff'* as a very important benefit of CPD only 37% rated *'learning skills for specific clients' and* 35% *'keeping up with new developments*',

Summary

The professional bodies (BACP, UKCP and BPS) all require members to plan their CPD by using a variant of a *'learning cycle'*: valuation, reflection, planning and action. And yet, despite this stipulation, in personal experience, informal discussions and both the qualitative and quantitative research I found little evidence that this was how therapists approached their professional development. The choice of what CPD was undertaken was much more to do with what interested the therapist, or who was delivering the workshop, rather than being part of a plan.

Only a small percentage stated that they followed professional guidelines and planned their CPD; one could imagine more respondents being drawn to this 'correct' answer. No one indicated they *'comprehensively reflected on the quality and impact'* of their CPD and only 17.5% *'reflected on the quality and impact'* at all which could be taken as a further lack of support for the '*learning cycle'*.

Discussion

Therapists are committed to their professional and personal development

Both the qualitative and quantitative parts of my research indicated that psychotherapists and counsellors are highly committed to their development. In some cases they admitted to being driven, or obsessional, to learn as much as they can about the human condition and psychotherapy theory. This is in line with '*an intense commitment to learn, propels the development process'* identified as a theme for therapists (Rønnestad & Skovholt, 2013) and the theme of *'veracious learners'* identified as a characteristic of *'master therapists*' (Jennings & Skovholt, 1999) .

This high level of commitment to self-development contrasts with my experience of managers in the hospitality industry where, despite corporate encouragement and funding, very few are proactive in their development and many will express preferences such as *'I don't really like reading long articles'* when confronted by a few pages from Harvard Business Review.

Therapists are required to plan their CPD

Virtually all professionals are recommended to complete CPD and, for an increasing number, this is either a mandatory or legal requirement of practice. Numerous professional organisations have recommended the *'Kolb Learning Cycle'* (Kolb, 1984) as best practice for a considered approach to CPD. The use of this *'ouput'* model is hard to monitor; whilst the simpler measurement of CPD undertaken, an *'input'* model, assesses only the one aspect of the cycle but is objective and simple to measure.

The UKCP follows an input measurement approach, except for the *'five-year peer review'* where the emphasis is on demonstrating a more reflective and planned approach to one's development. The BACP's approach is based on the Kolb cycle and participants must, if audited, describe how they completed the four phases of the cycle. Audits only impact a small percentage of the membership and there is nothing, in practice, to stop someone who is audited from retrospectively describing their CPD in terms of a planned, reflective process - even if this was not actually the case.

Most therapists do not plan their CPD

The qualitative research indicated that the participants did not plan their CPD – all indicated an emergent process driven by interest and passion. Two indicated an almost visceral reaction to being required to plan and structure their CPD.

The quantitative survey also indicated that only a small percentage of participants plan and reflect on their CPD in line with BACP requirements.

Life experiences

In response to the question, what develops you as a therapist, above formal CPD, participants identified life experiences: births, deaths, working in groups, being treated as a colleague. This is supported by Rønnestad and Skovholt (2001) study of senior psychotherapists which identified four primary *'learning arenas'* for professional development: professional experience, interaction with professional elders, and experiences in both early and adult personal life. Further evidence for the importance of life experiences were found by Rønnestad and Skovholt (2013) where therapists rated *'interaction with clients'* as most impactful for their professional development with '*supervision'* and *'personal therapy'* second and third, and *'personal life'* was frequently rated fourth.' Courses, seminars, books and journals were rated as less important whilst '*Clients as primary teachers'* and '*Personal life impacts professional functioning and development throughout the professional life span'* were seen as important sub-themes.

CPD requirements

It makes sense that maintaining skills and knowledge in a fast moving profession, with rapidly changing technology and new advancements in technique and resources, or where there are changes in law or regulations, is critical.

In psychotherapy, where so much of the evidence supports the notion that it is the relationship, not the technique, that makes the difference then the requirement for mandatory CPD is less obvious. Currently the UKCP requires 250 hours of CPD, over a period of five years, this is the same number of hours as the General Dental Council requires of dentists. In terms of the difference in technical knowledge required and the pace of technology change it seems illogical, to require a similar amount of CPD for dentists and psychotherapists.

If a relatively high level of CPD is not required to maintain knowledge in a changing environment then what other possible reasons could there be for it?

Differing opinions about the professional status of psychotherapy were very evident in the aborted moves to regulate the profession by legal statute: some camps wanting more regulation and alignment with the positivist *'medical model'* whilst others wanting less controls and to distance themselves from a scientific base. Perhaps high levels of CPD could be construed as part of an attempt to present the profession as evidence based and scientific on a par with medical doctors and dentists.

Alternatively one could argue that, although one does not need to understand the latest research to be an effective therapist, a constantly changing client list and the limited nature of initial training do necessitate that a clinician refreshes and enhances their skills.

What activities should constitute CPD?

Different professions approach the subject of what counts as CPD in different ways – BACP and UKCP provide lists of possibilities; in practice it appears that most anything with the vaguest connection to the profession can be pulled into the service of achieving the required hours.

There seems to be a belief that *'real CPD'* is where a certificate-of-attendance is issued but for the development activities that were most valued, (life experiences, learning from clients and supervision) no certificates can be issued.

Conclusion

Therapists are in general highly committed to their personal and professional development. Although required to plan their CPD, in practice it is generally more emergent than planned. Development activities that impact the ability to relate to clients are valued over more technique driven and didactic learning experiences. Perhaps such relational development activities, whilst allowed under the broad definitions of CPD, should be more encouraged by the professional bodies over the *'medical model'* workshops and qualifications.

Further Questions:

- Can CPD, particularly at the level currently set, be justified on grounds of safety to practice or for maintaining best practice?
- If following the Kolb learning cycle is best practice for CPD then should all regulating bodies adopt this in a more prescriptive and measurable way?
- Should the current system of allowing virtually any vaguely related learning to count towards the required CPD be tightened and are there specific areas of legislation, ethics, etc that could be considered for mandatory regular CPD?
- Should more relational development, for example, personal therapy, peer groups, mindfulness, arts and culture, be encouraged above workshops, books and courses?

Bibliography

Argyris, C., & Schön, D. (1996). *Organizational Learning II.* Reading: Addison-Wesley.

Brundage, D. H., & Mackeracher, D. (1980). *Adult Learning Principles and their Application to Programme Planning.* Ontario: Ministry of Education.

Cheetham, G., & Chivers, G. (2001). How professionals learn in practice: an investigation of informal learning amongst people working in professions. *Journal of European Industrial Training*, 248-292.

du Plock, S. (2014). Making an Impact. In S. Bager-Charleson, *Doing practice-based research in therapy* (pp. 170-179). London: Sage.

Elkin, I., Falconnier, L., Martinivich, Z., & Mahoney, C. (2006). Therapist effects in the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *Psychotherapy Research*, 144-160.

Ericsson, K. A. (2004). Deliberate practice and the acquisition and maintainance of expert performance in Medicine and related domains. *Academic Medicine*, S70-S81.

Frank, J. B., & Frank, J. D. (1991). *Persuasion and Healing.* Johns Hopkins University Press.

Friedman, A., & Woodhead , S. (2008). *Approaches to CPD Measurement.* PARN.

Goss, S., & Mearns, D. (1997). A call for a pluralist epistemological understanding in the assessment and evaluation of counselling. *British Journal of Guidance and Counselling*, 189-198.

Grayling, A. (2001). *The meaning of things.* London: Phoenix.

Hansen, J. T. (2014). *Philosophical issues in counseling and psychotherapy.* Lanham: Rowman & Littlefield.

Jarvis, P. (1984). Andragogy: a sign of the times. *Studies in the education of adults*, 32-38.

Jennings, L., & Skovholt, T. M. (1999). The cognitive, emotional and relational characteristics of master therapists. *Journal of counseling psychology*, 3-11.

Knowles, M. S. (1980). *The modern practice of adult education.* Englewood Cliffs: Prentice Hall Regents.

Kolb, D. A. (1984). *Experiential Learning: Experience as the Source of Learning and Development.* Englewood Cliffs: Prentice Hall.

Kvale, S. (1996). *Interviews: An introduction to qualitative research interviewing.* London: Sage.

McLeod, J. (2001). *Qualitative research in counselling and psychotherapy.* London: Sage Publications Ltd.

McLeod, J., & McLeod, J. (2014). *Personal and professional development for counselors, psychotherapists and mental health practitioners.* Maidenhead: Open University Press.

Miller, S. D., Hubble, M., & Duncan, B. (2008). Supershrinks: What is the secret of their success? *Pyschotherapy in Australia*, 14-22.

Okiishi, J., Lambert, M. J., Nielsen, S. L., & Ogles, B. M. (2003). Waiting for supershrink: An empirical analysis of therapist effects. *Clinical Psychology and Psychotherapy*, 361-373.

Orlinsky, D. E., & Rønnestad, M. H. (2005). *How psychotherapists develop.* Washington: American Psychological Association.

Professional Associations Research Network. (2008). *Analysis of survey of Professional body members on continuing professional development (CPD), Higher education Institutions (HEIs) as providers of CPD, and online delivery.* PARN.

Ricks, D. F. (1974). Supershrink: methods of a therapist judged successful on the basis of adult outcome of adolescent patients. In D. F. Ricks, M. Roff, & A. Thomas, *Life history research in psychopathology.* Minneapolis: University of Minneapolis.

Robson, C. (2011). *Real World Research.* Chichester: John Wiley & Sons Ltd.

Rønnestad, M. H., & Skovholt, T. M. (2001). Learning arenas for professional development retrospective accounts of senior psychotherapists. *Professional Psycholgy: Research and Practice*, 181-187.

Rønnestad, M. H., & Skovholt, T. M. (2013). *The developing practitioner.* New York: Routledge.

Schön, A. D. (1983). *The Reflective Practitioner.* Aldershot: Ashgate.

Smith, J. A., & Osborn, M. (2008). Interpretative Phenomenological Analysis. In J. A. Smith, *Qualitative psychology - a practical guide to research methods* (p. 53 to 80). London: Sage.

Sperry, L. (2010). *Core competencies in counselling and psychotherapy: becoming a highly competent and effective therapist'.* New York: Routledge.

Wampold, B. (2001). *The great psychotherapy debate: Models, methods, and findings.* Mahwah: Erlbaum.

Wampold, B. E., & Brown, G. S. (2005). Estimating variability in outcome attributable to therapists: A naturalistic study of outcomes in managed care. *Journal of consulting and clinical psychology*, 914-923.

Williams, C., & Hanson, W. (2011). *Moving to compulsary CPD.* London: PARN.

Yalom, I. D. (2015). *Creatures of a day and other tales of psychotherapy.* London: Little, Brown Book Group.

Appendix 1 - Analysis of quantitative data

What motivates you to undertake CPD? Please indicate your top three.

Follow my passions	71%
I'm interested in the subject	63%
To learn skills to support my clients	61%
Professional requirement	24%
I like the speaker	22%
To fill gaps in my training	19%
To feel more confident/less anxious	15%
Current client issues	10%

The most chosen motivating factors were *Follow my passions', 'I'm interested in the subject' and 'Learn skills to support my clients'.*

Whilst the lowest were *'Professional requirement', 'I like the speaker', 'To fill gaps in my training'* and *'To feel more confident/less anxious',* the very lowest with only 10% choosing it as one of their top three reasons to undertake CPD was 'Current client issues'.

Commentary: It could be assumed that for therapists following a planned approach to CPD the three most important factors would be: 'To fill gaps in my training', 'To feel more confident/less anxious' and 'Current client issues'. Whilst the choice of *'follow my passions'* and *'I'm interested in the subject'* suggest a more spontaneous approach. The *'Learn skills to support my clients'* could be considered a catch-all motivation.

CPD - Planned or spontaneous?

Totally planned	5%
Mostly planned	25%
Partly planned	40%
Mostly spontaneous	28%
Totally spontaneous	2%

If you plan your CPD – which of the following do you do?

	Never	Rarely	Sometimes	Most times	Always	Not appl.
Discuss CPD in supervision	11%	17%	58%	8%	6%	0%
Analyse current client issues	0%	18%	38%	29%	15%	0%
Keep a reflective journal	44%	16%	25%	12%	0%	3%
Discuss with line manager	31%	3%	23%	6%	6%	31%
Prepare a personal development plan	34%	23%	23%	17%	3%	0%

30% of the sample said that their CPD was totally or mostly planned whilst a similar percentage reported that their CPD was totally or mostly spontaneous with the remaining 40% reporting that they partially planned CPD.

Only 20% reported preparing a personal development plan whilst 57% never or rarely do this. CPD was discussed in supervision at least sometimes by 72% of participants. 60% rarely or never keep a reflective journal. The most common activity was '*analysing current client issues'* with 82% at least sometimes doing this. Significantly only 3% always '*prepared a personal development plan'*, 15% always *'analysed current client issues'* and 6% always discussed CPD in supervision.

Comments:

- *Personal development plan is mainly in my head and on scraps of paper.*
- *Analysing client issues isn't a prime input to my CPD plans. My interest normally leads - though my interest is usually aroused because of difficulties or impasses I am experiencing.*
- *I am always interested in more things than it is possible to do in any given time period.*
- *Though my way of 'planning' is informed by being reflective and allowing figural issues to emerge alongside being aware of what supports my passions and my client caseload and the contexts I work in.*
- *I look out for any CPD especially on Attachment, Trauma and couples work as these are of particular interest and provide the biggest challenges to me in my work with clients.*
- *I have a yearly budget for CPD and plan according to it.*

Commentary:

The requirement of all the major professional bodies is that CPD is planned on an annual basis. Most respondents did to some extent '*analyse current client issues*' but only 5% always planned their CPD as required – whilst 30% stated that their CPD was all or mostly spontaneous. Most did not prepare a personal development plan or keep a reflective journal; whilst 28% rarely or never discussed their CPD in supervision.

How easy do you find it is to fulfil your professional CPD obligations?

Always over achieve	50%
Easy to achieve	28%
Just achieve	7%
Struggle to achieve	10%
Have to be creative to meet my obligation	3%
Not sure what the obligation is	2%

How much CPD do you do each year?

Number of hours	**None**	**0-25**	**26-50**	**51-75**	**76-100**	**101+**
How much do you do?	0%	15%	31	10%	26%	18%
How much do you feel you really need?	0%	16%	51%	11%	14%	8%
How much should be mandatory?	6%	36%	44%	8%	6%	0%

77% reported that they found it easy to achieve the CPD hours required by their professional body with 40% undertaking more than 75 hours.

54% completed more than 50 hours yet only 33% felt that they needed such levels and only 14% felt this level should be mandatory.

67% felt the current level was the maximum they needed and 86% that this was the maximum that should be mandated.

Comments:

- *The downside of CPD is that it is just so easy to do - but not so easy to integrate into your work.*
- *I work in different settings, two of which have their own organisational expectations/ offerings of CPD. I regard these as being additions or bonuses to the CPD I choose to do for my professional registration requirements or my own personal development.*
- *I dislike the requirement as often there aren't any workshops that I am interested in or to the level I'm after and attendance becomes a waste of time and money to just 'tick a box' for registration.*
- *The cost of CPD is very high and can be difficult to access quality events if you live away from London or Midlands.*
- *It is not clear what counts as CPD for my professional accreditation, so feel that I am sometimes winging it!*

- *It depends on what you count as CPD. I have just put training events and peer presentations and supervision.*
- *I don't know how much I need. What is important is that I keep fresh and interested in the work and CPD supports this. CPD comes in so many forms this is hard to answer.*
- *I find cost is a big factor.*
- *Amount of mandatory (should) depend on level and experience.*
- *I can't say how much should be mandatory - depends on individuals.*

Commentary:

It appears that most therapists do considerably more hours than are required but believe that they do not need as much as they do and that less should be mandated. Individuals commented that the level of CPD should relate to experience and that hours averaged over a longer period would help effective planning.

Do you think the current level of information about your CPD required by the professional bodies is:

Too onerous	5%
A bit onerous	12%
About right	58%
A bit lax	20%
Much too lax	3%
Not sure what is required	2%

Commentary:

Except in the event of an individual's CPD submission being chosen for a random audit the current level of information required by the professional bodies is modest. 58% of respondents felt this is an appropriate level whilst almost an equal numbers felt it too onerous or too lax.

What sort of records do you keep of your CPD?

No record	0%
Basic details	43%
Details plus some reflection on the impact	40%
Details plus reflection on the quality and impact	17%
Details plus comprehensive reflection on the quality and impact	0%

Comments

- *I keep attendance certificate, full content and process notes, and notes to myself made during the course of things to think about / explore further later. But I do not keep notes/records of the quality and the impact - I just note these things in my head.*
- *My reflections are also embodied so I am also aware of the impact though developments in my practice and can reflect further through supervision.*
- *Having ticked basic details: I assimilate and accommodate the learning as I am processing client work on a continuous basis.*
- *I have lots of really exciting discussions with peers in response to CPD trainings and also articles we have read recently. This really enhances my work.*
- *We have set up a psychological therapies meeting every six weeks to take turns at presenting our own reflections on papers or CPD training days, and this helps digest the learning. It's no use just attending lots of days. If it isn't integrated into the work, then it is just indulgence.*

Commentary:

A number of respondents' comments alluded to the importance of integrating CPD with practice and recommended discussion with peers and in supervision. Yet despite the challenge of integration no respondents reported they *'comprehensively reflect on the quality and impact'* of their CPD and only 17% reported doing this on a regular basis. Whilst 40% keep only *'basic details'* of their development activities.

Can you think of specific instances of CPD that have impacted your clinical practice

None	0%
One or two	15%
A few	18%
More than a few	35%
Many	32%

Comments

Specific workshops

- *Trauma Choices and Neglectful Therapy by Miriam Taylor.*
- *Liminal Space with Sally Denham-Vaughan and Martin Capps various Family Constellations workshops.*

- *Family Constellations workshops affect everything I do in my clinical practice.*
- *Eleanor Greenberg conference, shame workshop, creative workshop.*
- *Three day Eleanor Greenberg training on personality adaptations.*
- *A lecture by Felicity de Zuluetta on clinical working with survivors of sexual abuse by fathers alerted me to the fact that clients usually experience more repressed anger/rage towards the mother who turned a blind eye to their suffering than to the father or perpetrator himself.*
- *Score affect regulation Valerie Sinason multiple personality disorder and disorders associated with adult sexual abuse.*
- *A weekend workshop on working with trauma safely, was very helpful when soon after a client of mine came into the room and dissociated.*
- *CPD on psychiatric diagnosis was very helpful to me in attending meetings with my client's psychiatrist.*
- *De Lisles workshop on incorporating Object Relations into Gestalt Therapy. This expanded my clinical thinking and enhanced my clinical work.*
- *Getting feedback on supervisory skills at Rich Hycner workshop.*
- *Using trauma treatment techniques after trauma training. Working much more with relational ruptures after Lynne Jacobs training.*
- *Trauma workshop that supported both my calmness and resilience with clients, as well as supporting their self-regulation/ stability.*
- *An international workshop organised by a process oriented psychology association helped me to find a new language and experiment with what I knew around the type of psychotherapy I trained. It was both inspiring and challenging.*
- *Working with victims of sexual abuse, PICT training helped positively impact how I work with clients.*
- *I used learning from an embodied resourcing workshop to self-support myself better in sessions with particular anxious or difficult clients.*

General comments

- *Lots of phrases and tone of voice/energy/presence taken from trainers which I adapt and make my own with my clients. E.G. how to offer an experiment or a reflection lightly so client has chance to reject it or take it and adapt it to make it their own.*
- *Lots of ways of thinking/values/attitudes to support my clinical decision making –e.g.:*
    - *is it better to be focusing on the relationship now, or on something else.*

    - *would going to body process deflect from something more important relationally right now.*
    - *learning signs of ANS arousal and using this to assess if client is outside window of tolerance etc.*

- *Attending presentations, reading and supervised practice integrating Acceptance and Commitment, Compassion Focus and Mindfulness based practice into my multi-modal approach.*
- *Sometimes it's not necessarily the facilitator but conversations with fellow therapist.*
- *The impact of language used by the therapist towards clients bringing issues of sexual abuse.*
- *Using a specific approach the next time I have met with a client for whom it is appropriate e.g. trauma focussed work.*
- *I have used my learning with clients, supervisees, colleagues and training days for support staff. It has transformed my work. CPD on trauma, both WPP training and the All Wales Network of Psychotherapy conference a few years ago. I use this training all the time.*
- *The recent presentation (and subsequent reading of her book) by Miriam Taylor has supported my development further, and I am using this work very specifically in my planning, reflection, supervision, and staff training. At Gestalt conferences I always come back refreshed. I have had the opportunity to work with inspirational practitioners. As a result I have become more competent and had more possibility in my work.*
- *I now ask about the relationship in a new way, bring it alive. Look at attachment and stages of development within a relationship. Look at genders how it affects people.*
- *The greatest impact has usually been with colleagues around a CPD event e.g. at a therapy residential with senior therapists around from around the world, greatest benefit gained was during informal discussions on theory and related topics.*

Commentary:

'Put on the spot' in the qualitative interviews participants identified few specific instances where CPD had had a direct impact on their clinical practice. Respondents to the questionnaire identified more, but only 32% said they could identify many instances whilst 33% could only think of a few or less.

Working with trauma and sexual abuse were highlighted as major areas where CPD had had clinical application – perhaps more emphasis should be put on these challenging areas in initial training.

Please rate the following activities in terms of value to your development

Activity	Very valuable	Somewhat valuable	Very + somewhat valuable
Learning from clients	75%	25%	100%
Supervision	73%	25%	98%
Life experiences	75%	22%	97%
Reading	50%	45%	95%
Multi-day workshops	70%	22%	92%
Peer groups	38%	47%	85%
One-day workshops	42%	40%	82%
Supervising	31%	33%	64%

Commentary:

All of the key areas of development were recognised as being valuable. Whilst none of the top three would be considered as formal CPD. *'Multi-day workshops'* score much higher than *'One-day workshops'*.

'*Reading*' does not get such high *'very valuable'* rating but the addition of the '*somewhat valuable'* score moves it into the mid-90s – suggesting, perhaps, a split between readers and non-readers.

Please rate the following benefits you get from your CPD

Benefit	Very important	Somewhat important	Very + somewhat important
Learning interesting stuff	67%	30%	97%
Keep up to date with new developments	35%	50%	85%
Learning skills for self-support	45%	37%	82%
Feeling I am doing the best I can	44%	36%	80%
Gain support from colleagues	40%	40%%	80%
Learning skills or techniques for specific clients	37%	40%	77%
Feel more secure/less insecure	23%	31%	54%
Feel more professional	15%	44%	59%
Learning skills that could help grow my career or business	26%	28%	54%

Commentary:

Virtually every respondent highlighted *'learning interesting stuff'* as an important benefit of CPD. *'Keeping up-to-date', 'skills for self-support', 'feeling I'm doing the best I can' and 'gaining support from colleagues'* were all seen as more beneficial than *'learning skills or techniques for specific clients'*.

Again I would suggest that this prioritising of benefits suggests a fascination with the theory and new developments in psychotherapy; but CPD that supports a planned approach relevant to the current clinical demands or stage of career is viewed as less important.

Demographics – 41 responses

Female 75% Male 25%

Experience	
less than 5 years	15%
5 to 10 years	18%
10 to 15 years	26%
15 plus	41%

Age	
30 to 40	8%
41 to 50	31%
51 to 60	43%
61 to 70	15%
71 plus	3%

Self-employed: 51% Employed: 13% Both: 36%

Humanistic: 77% Integrative: 11% Psychodynamic: 12%

Appendix 2 - Themes of therapist/counsellor development

(Rønnestad & Skovholt, 2013)

Theme 1:
Optimal professional development involves an integration of the personal self into a coherent professional self.

Theme 2:
The modes of therapist/counsellor functioning shifts markedly over time - from internal to external to internal.

Theme 3:
Continuous reflection Is a prerequisite for optimal learning and professional development at all levels of experience.

Theme 4:
Professional development is a lifelong process.

Theme 5:
Professional development is mostly a continuous process but can also be intermittent and cyclical.

Theme 6:
An intense commitment to learn propels the developmental process.

Theme 7:
Many beginning practitioners experience much anxiety in their professional work. Over time, anxiety is mastered by most.

Theme 8:
Interpersonal sources of influence propel professional development more than 'impersonal' sources of influence.

I. Clients are primary teachers.

II. Personal life Influences professional functioning and development throughout the professional life span.

III. New members of the field view professional elders and graduate training with strong affective reactions.

Theme 9:
Not all therapist/counsellors develop optimally.

Theme 10:
For the practitioner there is a real realignment of self as powerful to client as powerful.

Appendix 3 – Extracts from 'Creatures of a day and other tales of psychotherapy'

Irvine Yalom is in his eighties and still practising as a therapist. The following extracts are from his latest book '*Creatures of a Day and other Tales of Psychotherapy*' and, I believe, highlight some of the key concerns I have identified i.e. that the focus of professional development for therapists should really be on personal development.

> *'The most important thing I, or any other therapist, can do is offer an authentic healing relationship from which patients can draw whatever they need.'* (Yalom, 2015)
>
> *'In each instance, I devised, or sometimes stumbled on, a unique approach for each patient that would not be found in any therapy manual. Because we may never know with precision how we have helped, we therapists have to learn to live comfortably with mystery as we accompany patients on their journey of self-discovery.'* (Yalom, 2015)
>
> '*Most training programs today (often under pressure by accreditation boards or insurance companies) offer instruction only in brief, 'empirically validated' therapies that consist of highly specific techniques addressing discrete diagnostic categories, such as depression, eating disorders, panic attacks, bipolar disease, addictions, or specific phobias. I worry that this current focus in education will ultimately result in losing sight of the whole person and that the humanistic, holistic approach I used with these ten patients may soon become extinct. Though research on effective psychotherapy continually shows that the most important factor determining outcome is the therapeutic relationships, the texture, the creation, and the evolution of this relationship are rarely a focus of training in graduate programs.'* (Yalom, 2015)

Appendix 4 - A 'balanced diet': a personal experience of CPD

> *'Emotional responsiveness, personal knowledge of theory and method, and judicious self-disclosure, represent three areas of concrete therapist decision-making and action within sessions. These are things that therapists do. The extent to which a therapist is able to exhibit generic therapeutic competencies, will depend on his or her degree of personal development in relations to these areas.'* (McLeod & McLeod, 2014)

For six consecutive years I attended an eight day Gestalt residential programme in the beautiful hills around Santa Barbara in California. Each year I returned from the residential feeling that I had grown as a person, and as a therapist, but spent much time struggling to understand what it was it about this particular experience that was so developmental. When I read the above quotation I realised that there was something about the completeness of the experience – it nurtured the different aspects necessary for growth.

Held each year in the spring, approximately 30 therapists, with an interest in Gestalt or a relational approach to therapy and life, gathered to work, live, eat and play in the restful surroundings of citrus groves and humming birds. Participants came from different parts of the world; many from California, others from the US east coast or further afield including Australia, Germany, Great Britain, Greece, Korea, Mexico and New Zealand. Most returned year after year and developed strong enduring friendships; others came for one year, met for the first time, never to return. One or two are trainees, most are seasoned professionals who have often practiced, supervised and taught for years; there was always a smattering of professors, authors, heads of institutes, heads of clinical services, and doctors but all held their credentials and achievements lightly – they are there to learn.

The faculty is led by Lynne Jacobs, a therapist, academic and teacher of international renown. Providing a counterpoint to Lynne was the elder statesman of Gestalt, Gary Yontef – author of *'The Book'* that we all have a thumbed copy of. And as if Lynne and Gary weren't enough this formidable duo are supported by five more therapists with a colossal wealth of experience, knowledge, skill and humility. Most years a prominent teacher, usually from a different country or modality, was added to the mix – and although I wouldn't have missed the experience of working with, and learning from, any of the faculty, in practice any one of them on their own, could have kept me engaged for the eight days.

The routine of the day is governed by the bell that summons participants for meals; my personal routine was to get up early and go for a brisk walk, then be first to the breakfast room, to sit at communal tables with whoever of the participants or faculty might join me. Then to the lecture, my least favourite part of the day, as, for some reason, only one of the speakers in six years saw fit to support his excellent presentation with audio visual. The message might be powerful, personal and emotional and it deserves to be heard – but there seems to be a reluctance to give it the presentation support it merits.

After the lecture, and possible discussion, participants head off to home group. I grab some caffeine and sugar on the way.

The home group can range in number from eight (I'm feeling very comfortable) to 12 (I'm getting a bit lost), we meet every day for two 90-minute slots. We are facilitated by a rotation of faculty – they can take firm control of the group or hold their responsibility very lightly depending on their style and the current needs of the group. Our group is pretty self-facilitating and most of us have been in this same group for a few years. Someone may claim time or we will sit quietly, looking at our feet or making shy eye contact until someone either checks-in or makes a statement to an individual or the group. The conversation may build on the previous theory section but talking about stuff outside of the room is frowned upon and most talk will be of how individuals are feeling, the impact they are having on others, what one person may represent for another. For me I get to practise my interpersonal skills and improve my self-awareness; I am often challenged for being quiet, I sometimes don't get to say what I want, and sometimes, just sometimes, I get to say something that might capture a moment or a feeling. A week doesn't pass without me in floods of tears and this feels a good place for that; a place to be supported and to support, a place to be challenged and challenge.

In the afternoon are the practice groups, a rare opportunity to be a client and work on my own issues, or to be a therapist and work in front of a talented team of live supervisors. And if I am not working as either a client or a therapist I get to watch, listen and learn. I get to watch a piece of therapy and then declare the emotional resonances I have to the client's story and I get to structure my thoughts about the piece of work and give feedback in a way that is helpful to the therapist.

At lunch I have to choose how to look after myself – I eat lunch but then have time to sleep or read, or walk with a friend or ride out for coffee with some guys I barely know.

There are three challenging times for me: on Monday, the day off, we have to make our own arrangements for dinner – do I go with a group which may be too big, or risk being on my own? On Thursday, the last night, there is a self-organised party - how can I best contribute – how much should I give of my time and energy? On Friday when we say goodbye, I have to speak in the large group; how can I be original, sincere and still be funny? These are challenges for me of how to be with people.

For six years I didn't make any CPD choices except to rebook. Attending the residential ticked all my CPD boxes; it gave me enough CPD hours, it gave me my Gestalt specific hours, professional development was covered by the live supervision and the theory group, whilst personal development was covered by the process group and the social interaction of the community, cultural development was enhanced by being in a foreign country (the USA is more foreign than it first appears) whilst sense of self-worth was both challenged and enhanced by being in this community and being with very important therapists and some very special friends – and some people played both roles for me.

The PGI residential - continuing professional development in a box; the complete diet for professional and personal growth!